COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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PHONE: (208) 334-6626
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June 8, 2009

Tom Whittemore
Communicare, Inc #4 Leland
40 West Franklin Road, Suite F
Meridian, ID 83642

RE: Communicare, Inc #4 Leland, Provider #13G012

Dear Mr. Whittemore:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Communicare, Inc #4 Leland, on June 4, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 22, 2009,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 22, 2009. If a request for informal dispute resolution is received after June 22, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G012	A. BUILDING ______ B. WING ______	06/04/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNICARE, INC #4 LELAND	**4150 LELAND WAY** **BOISE, ID 83709**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Communicare #4 - Leland is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Sherri Case, LSW, QMRP	W 000	RECEIVED JUN 11 2009 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: administrator — (X6) DATE: 6-9-2009

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual licensing survey. The survey was conducted by: Jim Troutfetter, QMRP Team Leader Sherri Case, QMRP	M 000		
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all toxic chemicals were stored under lock and key for 1 of 1 individuals (Individual #1) who attended the day program. The findings include: 1. During an observation at a day program facility on 6/2/09 from 11:10 a.m. - 12:11 p.m., a storage closet was noted to be open. The closet contained the following chemicals: - A container of Morning Mist disinfectant with a label stating "May be fatal if absorbed through the skin" and "Causes irreversible eye damage and skin burns." - One 1 gallon container of bleach. - 4 spray cans of Citrus Splash with a warning label stating it was flammable and to avoid contact with eyes and skin. - 8 spray cans of glass cleaner. - 5 one gallon containers of Sundance floor cleaner with a label stating it was an eye irritant.	MM271	RECEIVED JUN 11 2009 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: admin (X6) DATE: 6-9-2009

Bureau of Facility Standards

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MM271	Continued From page 1 During an interview at the facility on 6/2/09 at 11:56 a.m., the AQMRP stated the door could not be closed and that maintenance had been notified. When asked during an interview on 6/4/09 from 9:55 - 10:55 a.m. the QMRP Supervisor stated the door should have been fixed so the door could be closed and locked. The facility failed to ensure all toxic chemicals were in appropriate areas under lock and key.	MM271	The day treatment Center was in its second day of operation after a fire and the related repairs were completed. The door to the supply room had not been closed as supplies were being purchased and placed into the room. It is our policy to securely lock supplies which might be harmful. In this instance it was found went an attempt to close the failed that the new carpet strip prevented the door from closing. Our maintenance man completed the necessary repair before the end of the day that the problem was noted. In keeping with our policy the door is locked when clients are in the building.	6-4-2009
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. The findings include: An environmental survey was conducted on 6/2/09 from 2:40 - 3:00 p.m., and the following concerns were noted: - The sink in Individuals #3 and #4's bathroom was slow to drain. - There were small bleach spots and black marks on Individual #3's comforter.	MM380	MM380 The sink drain in person's 3&4's bathroom has been cleared and is routinely monitored to assure it is flowing properly. The comforter in question belongs to person 3, and he has not wanted to replace it. We will purchase a comforter and offer it to him as we normally supply such items. The knob on the dresser has been replaced. Person 1 likes to remove the knobs so we will attempt to glue the knob in place. The drawers in person 7's now close properly. His winter clothing has been stored in another location. The damaged linoleum will be replaced. The Administrator	9-4-09

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MM380	Continued From page 2 - There was a knob missing on the third drawer of Individual #1's dresser. - The third drawer of Individual #7's dresser did not close completely. - There was torn linoleum in front of the kitchen sink.	MM380	overlooked this but will see that the work needed is accomplished. All of the above items are included on the monthly preventative maintenance check list and will be monitored by the AQ and the Administrator on a monthly basis.	